DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085001	A. BUILDING _____ B. WING _____	C 10/24/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENTMERE	1900 LOVERING AVENUE WILMINGTON, DE 19806

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F 000	INITIAL COMMENTS An unannounced annual and complaint survey was conducted at this facility from October 14, 2011 and concluded on October 24, 2011. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility and hospital documentation as indicated. The facility census on the first day of the survey was 99. The Stage 2 survey sample totaled 37 residents.	F 000		
F 156 SS=C	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)	F 156	1. Once informed by the surveyor the mandatory postings were prominently displayed in the facility. 2. All residents have the potential to be affected by failure to post mandatory information in a prominent area in the facility. 3. Weekly Administrative Environmental checklist has been revised to include checking for mandatory postings. (Attachment A) 4. Weekly Administrative Environmental Rounds checklist will be reviewed by the Administrator on a weekly basis.	10/18/11 12/20/11 Ongoing

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Eileen Malle ADMINISTRATOR 11/18/11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 156	Continued From page 1 (i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance	F 156		

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F 156	Continued From page 2 directives requirements. The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on observations throughout the building and staff interviews, it was determined that the facility failed to display a posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network,	F 156		

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F 156	Continued From page 3 and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility. Findings include: Observation of the facility ground, first, second and third floor hallways and common areas on 10/14/11 and 10/18/11 revealed the above listed information could not be found within the building. In an interview with E1 (Administrator) on 10/18/11, she confirmed this finding. On 10/18/11 at 11:55 AM, E1 indicated that the sign for the advocacy group signs were up on all floors. She stated they had the advocacy group signs posted prior to the new construction that they had completed at the facility recently and forgot to repost the signs. In an interview with E6 (Unit Manager 3rd floor, RN) on 10/18/11 at 8:30 AM, she stated the construction in the building ended at the beginning of this year (January or February 2011). In an interview with E8 (Maintenance Director) on 10/24/11, he stated they completed the construction in the building sometime in June of this year.	F 156		
F 167 SS=C	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for	F 167	1. Once informed by the surveyor, the most recent surveys were immediately placed in the front lobby, and a poster hung on each floor by the elevator informing residents where to locate the survey.	10/18/11

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F 167	Continued From page 4 examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Based on observations made throughout the facility and interview, it was determined that the facility failed to prominently post and display survey results for residents, family, and visitors. Findings include: 1. On 10/14/11, a tour of the facility's three units revealed a lack of signage indicating the location of the survey report. The survey report was located on top of the fire place mantel of the ground floor lobby area. There was no signage in that area indicating availability of the survey report. 2. On 10/14/11 and 10/18/11, a tour of the facility revealed a lack of signage on all four floors indicating the location of the survey report. On 10/18/11, E1 (Administrator) confirmed this finding regarding the lack of posting of a notice of the availability of the survey results.	F 167	2. All residents have the potential to be affected by failure to have most recent survey readily accessible area in the facility. 3. Weekly Administrative Environmental checklist has been revised to include checking for survey and postings. (Attachment A) 4. Weekly Administrative Environmental Rounds checklist will be reviewed by the Administrator on a weekly basis.	12/20/11 Ongoing
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's	F 279	1. R46 care plan was revised to include non-pharmaceutical interventions in conjunction with Xanax therapy. The care plan was also updated to include measurable goals and interventions that monitor the effect of the medication in	10/25/11

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F 279	Continued From page 5 medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to develop a care plan for one resident (R46) out of 37 sampled related to the use of an antipsychotic medication(Xanax) that includes non-pharmaceutical intervention in conjunction with the Xanax therapy. Findings include: R46's MDS assessments dated 6/2/11 and 9/14/11 identified that R46 was receiving anti-depressant drugs for mood disorder and diuretic. No antipsychotic drug. A physician's order dated 10/11/11 stated, "Xanax 0.25 mg PO BID and Q 6 PRN-anxiety" The facility failed to develop a careplan that would include measurable goals and interventions to monitor the effects of the medication in accordance with the physician's order and assessments and the current standard of practice.	F 279	accordance with the physicians order assessments and the current standard of practice. 2. All residents who have physician order for Xanax therapy has the potential to be affected by this citation. All residents that receive Xanax therapy will have their care plans reviewed and revised accordingly. 3. (A) The Staff Educator will educate Unit Manager and Social Services Director on including non-pharmaceutical interventions on residents receiving Xanax Therapy. (B) The Staff Educator will educate Nursing Staff on including measurable goals, and interventions that monitor Xanax Therapy in accordance to standard of practice, and physician ordered assessments. (C) The Social Service Director/Designee will randomly audit care plans of residents receiving Xanax therapy for compliance. (Attachment B) 4. Audits will be reviewed in quarterly QA & A until substantial compliance is achieved. (Attachment C)	12/20/11 12/20/11 12/20/11 Ongoing Ongoing

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F 279	Continued From page 6 This finding was discussed with E1 (Administrator) and E2 (DON) on 10/24/11.	F 279		
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on record review, observation and interview, it was determined that the facility failed to ensure that one (1) resident (R89) out of 37 sampled, who entered the facility without pressure sores did not develop a pressure sore unless the individual's clinical condition demonstrates that they were unavoidable. According to R89's Minimum Data Set (MDS) assessments dated 3/03/11, 4/14/11 and 7/13/11, R89 was at risk for pressure ulcers but had no unhealed pressure ulcer at Stage 1 or higher. However on 8/09/11, R89 was discovered with an unstageable pressure ulcer on her left heel. Findings include: R89 had diagnoses that included HTN (hypertension), CVA (cerebral vascular accident) and senile dementia with depressive features and Peripheral Vascular Disease (PVD).	F 314	1. R89's interventions for her left heel pressure ulcer have been revised to reflect the resident's needs. 2. All residents that require extensive or total assistance for most of their ADLs (Activities of Daily Living) have the potential to be affected by this citation. All residents that are extensive or total assistance for ADL"s will have their interventions reviewed and updated accordingly to reflect the resident's need as it pertains to pressure ulcers. 3. (A) All Nursing Staff will be re-educated by the Staff Educator in the facility's Pressure Ulcer Prevention and Management policy. (Attachment D) (B) All Nursing Staff will be re-educated by the Staff Educator on the facility's Wound Identification Procedure (Attachment E) which has been updated to include a new Weekly Skin Assessment form	11/15/11 12/20/11 12/20/11 12/20/11

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F 314	Continued From page 7 R89 had a history of suspected deep tissue injury on her left heel, with an onset on 2/23/09. On 9/29/09 this wound became unstageable and healed on 3/10/10. The wound reoccurred and presented as Stage 2 on 6/17/10 which healed on 7/6/10. On 11/3/10, R89 was re-admitted to the facility from the hospital with a diagnosis of Urinary Tract Infection (UTI) and was assessed with a left scabbed heel wound.On 4/28/11, R89 was assessed to have a "1x1.4 superficial crevase (sic) like skinsplit" on her left heel which healed on 5/4/11. According to R89's MDS dated 7/3/11 this resident's cognitive skills for daily decision-making were moderately impaired. R89 required extensive to total assistance for most of her ADLs (Activities of Daily Living). R89 required assistance of two staff for bed mobility, transfers (with stand up lift) and toileting, and assist of one staff for bathing and dressing. She was dependent for wheelchair mobility and had no impairment in range of motion (ROM) of her upper and lower extremities. R89's Pressure Ulcer Risk Assessments, dated 4/25/11 and 7/18/11 indicated that she was at high risk for developing pressure sores. Review of the 7/13/11 MDS assessment revealed that R89 had no unhealed pressure ulcers Stage 1 or higher during this assessment period. The facility initiated a care plan, dated 5/27/08 and last revised on 3/11/11, entitled "Resident is High Risk for pressure ulcer/skin breakdown secondary to impaired mobility and urinary/fecal incontinence. She has DX (diagnosis) of PVD with delayed healing. She is dependent on staff for repositioning. She has exhibited a fluctuating	F 314	(Attachment F) and a New Wound Alert form (Attachment G) (C)The D.O.N./designee will randomly audit residents that are extensive or total assistance for most of their ADL's to monitor that interventions are current and are consistent with the resident's needs. 4. Audits will be reviewed in quarterly QA & A until substantial compliance is achieved. (Attachment H)	12/20/11 Ongoing

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F 314	Continued From page 8	F 314		

nutritional intake".
This care plan's interventions were:
a. See TAR (Treatment administration record) for preventative measures of heels
b. Monitor skin q (every) 2 hrs for s/sx(signs and symptoms) of potential breakdown (redness/discoloration, or open area), alert charge nurse if observed for notification of physician as needed to obtain treatment orders
c. Anti-pressure mattress, and cushion for chair
d. Provide a minimum of 12-16 oz of fluids per tray and encourage resident to consume
e. Assist to turn and reposition q 2 hrs
f. Keep skin clean and dry and bed linens clean/dry and wrinkle free as possible.
g. Incontinence care after each episode
h. Do not position directly onto trochanter when side-lying position used, maintain head of bed at lowest possible degree of elevation
i. Apply barrier cream per MD
j. Nutritional supplement as ordered

A nurse's note dated 8/9/11 and timed 0650 (6:50 AM) stated, "skin prep tx (treatment) to (L) heel as ordered completed. Noted a raised thick area of hard skin with black tissue. Surrounding skin red (blanchable), dry and intact. No drainage or odor noted. Raised thick area of hard skin measures approximately 2.1cm x 1.8 cm x 0cm. Bilateral heels offloaded on pillows while in bed. Allevyn foam applied on L (left) heel for protection. MD and unit manager notified.

R89's July/2011, August/2011's TAR for the facility's "Preventative measures for Heels" as per the care plan included "FYI (for your information) Off load Heels while in bed" and Elevate Legs while out of bed as she allows". Each block

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F 314	Continued From page 9 (represents days of the month) on the TAR had no single documented staff signature indicating that R89's heels were consistently offloaded. Review of nurse's notes for this same time period failed to indicate consistent offloading of the resident's heel and failed to note any refusals of the offloading by the resident. Additionally, the CNAs (Certified Nursing Assistant) Care sheets for the months of July/2011 and August/2011 also included instructions such as "Skin checks q 2 hrs and to report changes in skin to nurse". Although each dated daily block on all three shifts were signed off by the CNAs (indicating skin checks were completed every 2 hours on all three shifts), they failed to recognize and failed to identify signs and symptoms of an early stage of a developing pressure sore on the left heel prior to the discovery of her unstageable left heel pressure sore on 8/9/11. Additionally, the facility had a weekly "Skin Assessment/Body Checks" record form and assigned the 3-11 PM Nursing Staff to assess the resident's skin once a week (done every Tuesday). Staff nurse's signed off that the assessments were done on 7/5/11, 7/12/11, 7/19/11. 7/26/11, 08/2/11 and R89 refused on 8/9/11. There was no documentation of skin problems in nurses' notes and/or preventative measures/treatments initiated including a 24 hr Wound alert sheet. The 3-11 PM nursing staff failed to recognize/identify signs and symptoms of an early stage of a developing pressure sore on this resident's left heel. A Physician's History and Physical Examination, dated 8/3/11 stated, "1-2 + edema Left Lower tib (tibia) w/ 3 mm scabbed area. LE (Lower	F 314		

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F 314	Continued From page 10 Extremities)- edema slightly improved. scabbed area healing, skin-intact." However, it did not identify conditions of the left heel. Subsequently, a Weekly Wound Assessment, dated 8/10/11 stated findings of a left heel pressure wound unstageable 1.6 x 3 x UTD(unable to be determined), firmly adherent, brown no odor , no exudate edges defined which was first observed on 8/9/11. It further stated, "BLE (bilateral lower extremities) show 2+edema, cool to touch and chronic red toned in color. Unable to palpate pedal pulse. Feet are dry and flaky, thickened tissue noted." The facility's interventions noted on the Weekly Wound Assessment included the following:: Vitamins/Minerals Turning/Positioning schedule: q 2 hrs & PRN Support Surface; Standard pressure reduction mattress Cushions/pads/heel protectors: Incontinence management/toileting program: Incontinence care provided q 2 hrs and prn Skin Protection/N/A Current treatment: skin prep q shift, covered by non-adhesive foam dressing for protection, Off load heels while in bed, continue no shoe Under Hospice Benefit 8/17/11- Wound Assessment indicated some additional documented information, that is, resident has chronic issues to L heel; it is the site of a previously heeled ulceration on 7/6/10 and an area of thickened tissues noted on 11/3/10 and healed crevase like area on 5/4/11 same measurement as of 8/10/11.	F 314		

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F 314	Continued From page 11 9/1/11 - Wound Assessment; 9/8/11, 9/15/11, 9/23/11, 9/30/11, 10/7/11 measurement 1.6 x 2.8 x UTD no changes to treatment and rationale 10/18/11 - Wound Assessment: measurement: 2 x 2.8 x UTD, fibrotic/calloused/firm treatment - same interventions; Support surface: concave air mattress The MDS assessment, dated 10/05/11 indicated that this resident had a pressure ulcer Stage 1 or greater i.e.1 unstageable ulcer with suspected deep tissue injury in evolution. The facility failed to evaluate/identify R89's left heel pressure ulcer, failed to consistently monitor/implement interventions consistent with resident's needs and failed to revise the interventions as appropriate in a timely manner. This finding was discussed with E1 (Administrator) and E2 (Director of Nursing) on 10/24/11.	F 314		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323	1. Once informed by surveyor the soiled utility rooms and nutrition rooms were immediately secured. Automatic closures will be installed. 2. All residents have the potential to be affected by unlocked soiled utility rooms and nutrition rooms.	10/18/11 12/1/11

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F 323	Continued From page 12 This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, it was determined that the facility failed to maintain the environment free from accidents hazards, as evidenced by accessible and unlocked soiled utility rooms, utility rooms and nutrition rooms with hazard potential on all three residents units, including the dementia unit. Findings include: 1. Observations made on 10/14/11 at 9:40 AM revealed the third floor utility room door on the locked dementia unit was unlocked with contents accessible to residents and visitors. The room stored lockers and electrical panels. During an interview on 10/14/11 with E5 (LPN), she confirmed the room should be locked. 2. Observations made on 10/14/11 at 9:40 AM revealed the third floor (dementia locked unit) soiled utility room with contents unlocked and accessible to residents and visitors. The room stored bins of trash (1), soiled linens (1), infectious waste Biohazard (1), a bottle of Upholstery Stain Remover with label indicating "Caution: Keep out of Reach of Children. Avoid contact with eyes and skin. Do not ingest.", and bottle of a 2'n-1-Rug Spotter RTU indicating on label "Warning irritant. May be harmful if swallowed, inhaled or absorbed. " . In an interview with E6 (UM 3rd floor Dementia unit, RN) on 10/14/11, she confirmed the room should be locked. 3. Observations made on 10/14/11 at 11:30 AM revealed the third floor soiled utility room door on the locked dementia unit was unlocked with	F 323	3. (A) All staff will be educated on the need to secure utility and nutrition rooms. (B)Weekly Administrative Environmental checklist has been revised to include that utility room and nutrition rooms are properly secured. (Attachment A) 4. Administrative Environmental Rounds checklist will be reviewed by the administrator on a weekly basis.	12/20/11 12/20/11 Ongoing

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	085001	A. BUILDING _____ B. WING _____	C 10/24/2011

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F 323	Continued From page 13 contents accessible to residents and visitors. The room stored biohazard materials. In an interview with E9 (CNA) on 10/14/11, she confirmed the room should be locked. E9 attempted to close the door a few times, but it did not close. E9 stated then she would contact the maintenance staff to get it fixed. In an interview with E8 (Maintenance Director) on 10/14/11, he confirmed this finding. While doing a walk-thru of the floor with E8 (Maintenance Director) on 10/24/11 at 1:30 PM, the third floor soiled utility room was observed unlocked. E8 attempted to close the door a few times and it did not work. After numerous attempts, the lock finally closed. E8 stated he will continue to work on the door so it can work properly. 4. Observations made on 10/18/11 at 9:10 AM revealed the first floor soiled utility room unlocked with contents accessible to residents and visitors. The room was storing biohazards materials. In an interview on 10/18/11 with E10 (CNA), she revealed the room should be locked. She stated the door had a padlock, and therefore, she stated the door should be locked. Additionally on 10/24/11 at 11:30 AM, the first floor soiled utility room was observed unlocked. In an interview with E11 (Unit Manager RN 1st floor), she stated that the room should be locked as residents can wander in there and they had the biohazard container in that room. 5. Observations of the 2nd floor nourishment room on 10/24/11 at 1:35 PM with E8 revealed the door was unlocked and was accessible to residents, staff and visitors. The door had a lock on the door knob. In the nourishment room there	F 323		

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F 323	Continued From page 14 was a cabinet that contained an electrical panel which was also unlocked. E8 confirmed the door, or the electrical panel cabinet, should be locked. E8 proceeded to lock the door with a master key.	F 323		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to ensure that one (R60) out of 37 sampled residents was free	F 329	1. R60's Dilantin and BMP were drawn. 2. All new admissions have the potential to be affected by this citation. The D.O.N./designee will audit all new admissions within the last 30 days to ensure that physician ordered lab work was drawn. 3. (A) The Admission Checklist has been revised to include a double nurse check and monitors for completion of labs ordered upon admission, lab slips completed, and labs written in lab book and TAR. (Attachment I) (B)The staff educator will educate Nursing Staff on the revised Admission Checklist. 4. QA & A will be developed to ensure compliance of physician ordered lab work. (Attachment J)	10/19/11 12/20/11 12/20/11 Ongoing

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F 329	Continued From page 15 from unnecessary drugs. The facility failed to monitor laboratory values for R60 who was receiving Dilantin (anticonvulsant) and Losartan Potassium (for treatment of high blood pressure). Findings include: R60 was admitted to the facility on 9/26/11. Admission orders, dated 9/26/11 stated R60 was to have a BMP (Basic metabolic panel-monitors for electrolyte abnormalities and kidney function) and Dilantin level (measures level of medication in the blood) drawn on 10/3/11. Review of R60's drug regimen revealed she was receiving Dilantin and Losartan Potassium daily. The clinical record lacked evidence that blood work for a Dilantin level and BMP had been drawn on 10/3/11. Review of the facility's laboratory book (lists all residents who had blood work drawn on a specific date) with E4 (nurse) on 10/19/11 revealed that R60 was not listed to have a Dilantin level and BMP drawn on 10/3/11. E4 called the laboratory and was told that they had no laboratory results for R60 from 10/3/11. E4 subsequently ordered a Dilantin level and BMP be drawn. Review of R60's clinical record on 10/20/11 revealed that a Dilantin level and BMP were drawn on 10/19/11. The results revealed that the BMP was within normal limits. The Dilantin level was sub therapeutic at 6.1 (therapeutic range: 10-20 mcg/ml) indicating a need for an increase in dosage of the Dilantin. R60 did not experience any seizure activity since admission.	F 329		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY	F 371	1. The missing air gap was corrected by a plumber.	10/15/11

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F 371	Continued From page 16 The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based upon observations and interviews in the dietary area on 10/14/11, it was determined that the facility failed to prepare, distribute, serve and store food for the residents under sanitary conditions, in regards to a vegetable sink lacking an air gap in the drain pipe. Findings include: Observations of the vegetable sink in the kitchen on 10/14/11 revealed that the drain pipe was directly piped through the wall, and was missing an air gap at the exit of the drain pipe. E12 (Food Service Director) confirmed the absence of an air gap. In an interview with E8 (Maintenance Director) on 10/14/11, he stated he would get a plumber to work on the missing air gap. On 10/15/11, E8 stated the plumber installed an air gap on the exit drain line to the vegetable sink on 10/14/11. On 10/24/11, observation of the vegetable sink revealed an air gap on the drain line of the sink.	F 371	2. All residents have the potential to be affected by this citation. 3. Checking for proper air gaps will be added to the preventive maintenance (PM) list. (Attachment K) 4. The PM list will be reviewed by Administrator and Maintenance Director on a weekly basis.	12/1/11 12/1/11
F 412 SS=D	483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS	F 412	1. R2's dentures were repaired.	11/17/11

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F 412	Continued From page 17 The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist. This REQUIREMENT is not met as evidenced by: Based on record review and interviews, it was determined that one (1) resident (R2) out of thirty-seven (37) sampled residents did not receive a follow-up visit for dental services in a timely manner. Findings include: R2 was initially admitted to the facility on 10/2008 and re-admitted on 10/20/10 with diagnoses that included rheumatic arthritis, osteoporosis, ambulatory dysfunction, Degenerative Joint Disease (DJD), cervical spinal stenosis, status post (s/p) L2 decompression, Hypertension (HTN), obesity. R2 was on a regular consistency diet and her weight had been stable. R2 was alert and oriented X3. Observations of R2 on 10/17/11 at 11:35 AM revealed that she had one missing tooth on the top denture which needed repair. Dentures were observed on the bottom area of the mouth. In an interview with the resident (R2) on 10/17/11, she stated that she had had dental work and the facility, or dentist, did not follow up with her, and she had saved the tooth that came out.	F 412	2. Any resident that had a dental consult has the potential to be affected by this citation. Any resident that had a dental consult conducted in the last 90 days will be audited to monitor for follow up. 3. The Staff Educator will educate Nursing Staff on the proper procedure on following up on dental consults. 4. Audits will be reviewed in quarterly QA & A until substantial compliance is achieved. (Attachment L)	12/20/11 12/20/11 Ongoing

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F 412	Continued From page 18 Review of R2's quarterly oral assessments, dated 4/26/11 and 7/22/11, with E13 (RNAC) revealed that R2 was edentulous and had full upper and lower dentures, and had no issues with dentures (eating or chewing). In an interview with E13 on 10/19/11 at 2:38 PM, she stated she was unaware R2 was having any dental problems, and that R2 had not voiced any concerns to anyone about her dentures or teeth. She stated the resident was not care planned for dental care because she had no issues with her teeth and R2 was due for an assessment but was at the hospital as of 10/18/11. Review of R2's clinical record revealed that R2 had a dental consult on 2/4/11 that indicated the resident was seen by the dentist, and a note on the consult indicated that the dentist was waiting on R2's decision for further dental work due to cost. Review of nursing and social services notes from 2/4/11 to 10/21/11 indicated that R2 had no dental concerns. There was no evidence that staff were aware of R2's missing tooth in the upper top dentures. Facility documents reviewed from 2/5/11 to 10/21/11) revealed that no other follow up was set up for R2 by the dentist, social services, or nursing staff to determine if R2 wanted further work completed with her teeth. In an interview with E7 (Unit Manager RN, 2nd floor) on 10/19/11, she stated that oral assessments were done upon admission, quarterly, and then again only if a resident or staff reported a problem. She confirmed they failed to follow up on the dental consult dated 2/4/11 and	F 412		

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F 412	Continued From page 19 failed to arrange for R2 to see the dentist again after the 2/4/11 consult visit. The facility failed to provide a follow-up dental visit for at least eight months after a consult dental appointment that required R2 to make a decision on repairing her upper denture tooth which she complained about to the surveyor during the survey.	F 412		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and	F 431	1. Once informed by the surveyor, the expired vaccine was properly discarded. 2 .All residents have the potential to be affected by this citation. 3. (A) The Weekly Administrative Environmental checklist has been revised to include checking medication refrigerator for expired medications. (Attachment A) (B) Staff Educator will provide inservice to nursing staff on checking refrigerators and discarding expired medications. 4. Administrative Environmental Rounds checklist will be reviewed by Administrator/D.O.N. on a weekly basis.	10/18/11 12/20/11 Ongoing

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F 431	Continued From page 20 Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to ensure that the drugs and biologicals that were stored in the medication refrigerator were not expired. Findings include: An observation on 10/21/11 of the medication refrigerator on the third floor in healthcare revealed, that there were two bottles of Pneumococcal vaccine with expiration dates of 7/13/11 & 7/18/11 and one bottle of Influenza vaccine with an expiration date of 3/11/11. During an interview with E3 (RN) on 10/21/11 immediately after the observation, E3 confirmed these findings and disposed of the expired medications.	F 431		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control	F 441	1. (A) E6 was educated on infection control practices and the facility's policy for hand washing pertaining to non-sterile dressings. (B) E23 was educated on cleaning/wiping the drips from medication bottle. (C) E23 was educated on proper wound treatment protocol.	11/22/11 11/22/11 11/22/11

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F 441	Continued From page 21 Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observations and interviews, it was determined that the facility failed to maintain infection control practices designed to provide a safe, sanitary and comfortable environment, and failed to help prevent the development and transmission of disease and infection for three (R33, R1and R89) out of 37 sampled residents. It	F 441	(D) Once informed by the surveyor the immediate action was taken, the laundry and staff bathroom doors were immediately closed, and the window was shut. (E) Automatic door closures will be installed on the laundry and staff bathroom doors. (F) The vent grill in the laundry room is scheduled to be fixed. 2. All residents have the potential to be affected by this citation. 3. (A) The Staff Educator will educate all staff on the facility's Infection Control Program. (B) The Staff Educator will educate Nursing Staff on proper hand washing pertaining to non-sterile dressings, cleaning/wiping drips from medication bottle, and wound treatment protocols. (C) The Staff Educator will educate staff on closing laundry and bathroom doors in addition to closing the window in the staff bathroom.	10/18/11 12/1/11 12/20/11 12/20/11 12/20/11 12/20/11

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F 441	Continued From page 22 was also determined that the facility failed to prevent the spread of bacteria or infection when they failed to provide a room under negative pressure for the washing of soiled linen and were using a fan inside the washer room that raised contaminants into the air. Findings include: 1. An observation of R33 on 10/19/11 with E6 (RN) revealed that while completing a non sterile dressing change E6 did not wash her hands before putting on gloves, then proceeded to remove the dirty dressing on the sacrum and ischial wounds and disposed of the dirty dressing and gloves in the trash can. E6 did not wash her hands. E6 then proceeded to put on another pair of gloves and applied the treatment, after which E6 did not change gloves or wash hands and then applied a new clean dressing to the sacral and ischial wounds. An interview on 10/19/11 with E6 after the observation, confirmed that E6 did not follow infection control practices and facility policy for hand washing pertaining to non-sterile dressing changes. A review of the facility policy entitled, Dressing Change (Non-sterile) states, " ... ...5. Wash hands, 6. Don unsterile gloves, 7. Remove dirty dressing, 8. Dispose of dressing in trash bag, 9. Remove gloves and wash hands, 10. Open treatment items, don unsterile gloves, 11. Cleanse the wound, 12. Change gloves, 13. Wash hands, 14. Apply dressing per physicians order, 15. Wash hands. " 2. During the medication pass observation on 10/20/11 R1 was to receive 30 cc of Liquid cell supplement. When E23 (LPN) picked up the 32	F 441	(D)The Administrative Environmental Checklist will be updated to monitor that the doors to the laundry room and staff bathroom are closed, and the window in the bathroom is shut. (Attachment A) 4. Infection Control Program will be reviewed in quarterly QA & A until substantial compliance is achieved. This will include room treatment protocol hand washing, and medication storage and handling. (Attachment M)	Ongoing Ongoing

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F 441	Continued From page 23 oz bottle of the supplement, it was discovered that the bottle was covered with drips from the liquid supplement that dried up. The previous medication nurses stored the bottle in the medication cart without consistently cleaning/wiping out the drips from the bottle and it dried up. Cross-refer to F314 3. The E23 (LPN) failed to follow standard infection control practice in wound care treatment by exposing the left heel with the unstageable pressure wound to the bare floor in this resident's room. R89 had an unstageable wound on the left heel with tissue covering that was firmly attached (documented as fibrotic/calloused/firm, defined and attached) brownish, no drainage. The wound measured 2x2.8 x UTD on 10/18/11 R89's wound treatment was observed on 10/21/11 at approximately 10:00 AM R89, was seated upright in her wheelchair in her room. Wound care nurse E 23(LPN) removed the soiled dressing on the resident's left foot/heel while resident was seated upright in the wheelchair. E23 forgot to keep resident's edematous left leg/foot elevated after removing the left heel soiled dressing. R89's foot/heel was touching the floor's surface. Consequently, while E23 prepared her wound dressing supplies, R89's exposed left unstageable heel wound was not protected from external contamination while being in contact with the floor's surface without a protection and placed the resident's wound at risk for external contamination. 4. The facility's Infection Control Policy entitled "Infection Control in the Laundry Department"	F 441		

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F 441	Continued From page 24 was reviewed. The procedure did not address reducing contaminants in the air or that the laundry room area should be well ventilated and maintained under negative pressure to remove potential for spreading disease. Observations of the laundry room washer area with E14 (Director of Housekeeping) and E8 (Maintenance Director) on 10/21/11 at 3:30 PM revealed the exhaust vent grill in the room was not exhausting air out of the room. The washer soiled linen area was not observed under negative pressure and was missing a vent system that directly exhausted the dirty air to the outside of the facility. This had the potential for keeping the contaminated air inside the soiled linen washer area. Additionally on 10/21/11 at 3:30 PM, the soiled linen wash area of the laundry revealed the door was opened to the hallway across the kitchen, a fan was blowing the contaminated air within the washer area and outside in the hallway, and the door of a staff bathroom inside the washer area (with the window open) exhausting the dirty air though the staff bathroom. This had potential for spreading contaminated air through the hallway, the bathroom, and exposing other staff to the contaminated air in that room.	F 441		
F 518 SS=E	483.75(m)(2) TRAIN ALL STAFF-EMERGENCY PROCEDURES/DRILLS The facility must train all employees in emergency procedures when they begin to work in the facility; periodically review the procedures with existing staff; and carry out unannounced staff drills using those procedures.	F 518	1. E15, E16, E17, E19, E20, and E21 have been educated by the Staff Educator on Emergency Procedures/Drills. 2. All residents have the potential to be affected by the citation.	11/22/11 12/12/11

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085001	A. BUILDING _____ B. WING _____	C 10/24/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENTMERE	1900 LOVERING AVENUE WILMINGTON, DE 19806

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F 518	Continued From page 25 This REQUIREMENT is not met as evidenced by: Based on in-service documentation reviews and staff interviews, it was determined that although the facility trained their management staff on fire and hurricane emergencies, the facility failed to ensure that non-management or support staff such as two (2) CNAs (E15, E16), and one housekeeping staff (E17) of eight sampled staff were trained in emergency procedures when they began work at the facility or periodically thereafter. Additionally, the in-service records reviewed did not support that five staff (E15, E16, E19. E20, E21) reviewed attended emergency preparedness training. Findings include: Interviews with certified nursing assistants (E15, E16) and housekeeping staff (E17) on 10/19/11 and 10/24/11 confirmed they were familiar with how to handle a fire emergency but were not familiar with what to do in the event of an emergency such as a missing person, bomb threat or other pertinent facility emergency as stated in the facility's Emergency Preparedness procedures. Interviews with E19, E20, and E21 (CNA) at a later time on 10/19/11 revealed they were trained on emergency preparedness and they had hurricane emergency training recently. In an interview with E18 (Staff Development Nurse) on 10/19/11, she revealed that she did not do emergency preparedness training for the staff although she did cover all other nursing care topics such as abuse, dignity, etc. E18 stated she did not cover missing person or elopement	F 518	All staff's personnel files will be audited by the HR Director for proof of Emergency Procedure education. 3. (A) All staff that lack evidence of Emergency Procedure/Drills education will be educated by the Staff Educator. (B) The facility's mandatory and Annual New Hire Orientation program has been revised to include Emergency Procedure/Drills education. 4. QA & A will be developed to ensure that non-management staff are knowledgeable of Emergency Preparedness Procedures. (Attachment N)	12/20/11 10/24/11 Ongoing

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F 518	Continued From page 26	F 518		

training, and that the emergency preparedness training was provided by the maintenance director (E8).

In an interview with E8 on 10/21/11 at 2:21 PM, he revealed that during the new hire orientation, they did cover certain emergencies verbally but did not document who attended these sessions. E8 stated he covered chemical spills and conducted hurricane (Irene) training for the management staff only (all unit and department heads/managers, nursing supervisors). E8 stated non management staff such as CNA and housekeeping did not participate in the training. E8 provided a copy of the sign up sheets for all the management staff for the Hurricane training conducted on 8/25/11. E8 stated he did not cover missing person/elopement procedure training with the staff.

Facility in-service records were reviewed for five (5) CNA, two (2) nurses and one (1) housekeeping staff and findings are documented below for those with a concern. Documentation of in-service training to validate which staff had training was not available for new/ongoing orientation for emergency procedures training upon hire or ongoing for non management staff reviewed (E15, E16, E19, E20, E21 and E17).

1. E15 (CNA), hired on 5/31/11, had no emergency preparedness training upon hire. Missing/elopement training was missing from E15's in-service training records. In an interview with E15 on 10/21/11, she revealed she did not remember if she had the facility emergency preparedness training. E15 was not able to answer questions regarding emergency

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F 518	Continued From page 27	F 518		

preparedness correctly.

2. E16 (CNA), hired on 12/10/08, had no ongoing emergency preparedness training. Missing/elopement training was missing from E16's in-service training records. In an interview with E16 on 10/21/11, she revealed she did not remember if she had emergency preparedness training. E16 was not able to answer questions regarding emergency preparedness correctly.

3. In an interview with E17 (Housekeeping staff), hired on 7/12/04, on 10/24/11 at 11:30 AM, she stated she had no ongoing emergency preparedness training.

4. In an interview with E19 (CNA), hired on 1/24/05, she stated she had ongoing emergency preparedness training. Record review revealed that the Missing person/elopement and emergency preparedness training was missing from E19's in-service training records. No evidence existed she attended emergency preparedness training or missing person training.

5. In an interview with E20 (CNA), hired on 7/11/11, she stated she had emergency preparedness training upon hire. Missing person/elopement and emergency preparedness training was missing from E20's in-service training records. No evidence existed she attended emergency preparedness training or missing person training.

6. In an interview with E21 (CNA), hired on 1/24/05, she stated she had ongoing emergency preparedness training. Missing person/elopement and emergency preparedness training was

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F 518	Continued From page 28 missing from E21's in-service training records. No evidence existed she attended emergency preparedness training or missing person training. The in-service form entitled " Individual In-Service Record " indicated that staff had Annual Orientation for 4 hours upon hire or annually. Another in-service record form entitled " Core Competency Checklist " , indicated staff had customer service, employee handbook, residents rights, cultural competency, HIPPA, Infection control, Blood borne pathogens, Body Mechanics, Dementia, Fire Safety and MDS. The form was lacking missing person and emergency preparedness training. Item "10" of the checklist indicated that the staff had identified location, identified content of MDS, appropriate response to fire, (Dr. Red announcement), and lock out tag-out procedures training.	F 518		

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Long Term Care Residents Protection

DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 577-6661

STATE SURVEY REPORT

NAME OF FACILITY: Kentmere

DATE SURVEY COMPLETED: October 24, 2011

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. An unannounced annual and complaint survey was conducted at this facility from October 14, 2011 through October 24, 2011. The deficiencies contained in this report are based on observation, interviews and review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was 99. The survey sample totaled 37 residents.	
3201	**Skilled and Intermediate Care Nursing Facilities**	
3201.1.0	**Scope**	
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** **This requirement is not met as evidenced by:** Cross refer to the CMS 2567-L survey report date completed 10/24/11, F156,	Cross Reference to CMS 2567 F156

Provider's Signature Ellen Malk Title Administrator Date 11/21/11

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NAME OF FACILITY: Kentmere

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SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	F167, F279, F314, F323, F329, F371, F412, F431, F441 and F518.	Cross Reference to CMS 2567 F167, F279, F314, F323, F329, F371, F412, F431, F441, and F518.
3201.7.5	**Kitchen and Food Storage Areas.** **Facilities shall comply with the Delaware Food Code.** **5-402.11 Backflow Prevention.** **(A) Except as specified in (B), (C), and (D) of this section, a direct connection may not exist between the sewage system and a drain originating from equipment in which food, portable equipment, or utensils are placed.** **This requirement is not met as evidenced by:** Cross refer to the CMS 2567-L survey report date completed 10/24/11, F371.	Cross Reference to CMS 2567 F371